THE ROLE OF GOVERNMENT REGULATION*

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OVER the last two days we have heard a great deal about the potential advantages of this new competitive health care market. We have also heard a great deal about its potential disadvantages from David Calkins, for example, about impacts on the poor.

It seems to me that the core of these emerging problems is that this new competitive market, based on economically motivated behavior, is being imposed on a health system that was not built on competitive market premises. As a result, purely self-interested behavior by the participants in today's health system will produce very serious consequences for vulnerable populations and vulnerable institutions.

Our society can deal with these problems in two ways, both of which I want to talk about this afternoon. One is through socially responsible, ethically concerned behavior by various actors in the health system who should recognize that, if they pursue only their economic self-interest, they will produce socially undesirable results. Second—and it is a second-best solution in many instances—government regulation may have to be used where such self-regulating behavior does not occur.

Let us start by reminding ourselves of the two key problems in making a competitive market work in health care. The first is the number of the uninsured, which has grown from 25 million 10 years ago to more than 35 million today. Corresponding to that has been a drop in Medicaid program coverage from about two thirds of the poor to less than 50% of them. No responsible economic or competitive market theorist in the United States would argue that a competitive health care market will well serve people who cannot afford to pay competitive market prices. So that is the first concern: who will be responsible for the poor in this competitive market?

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The second large problem looming ahead is the high expense and high risk population. Many of these persons are now in employer groups, but with skimming of risk pools and employment practices to avoid covering high-risk individuals, they could find themselves joining the ranks of the uninsured.

I want to underscore my view that these are not purely problems for government. In a free society we look first to responsible behavior in the private sector to achieve our goals and then add government regulation only where behavior in the private sector does not produce socially acceptable results. These issues of social responsibility and ethics in a competitive health care market are thus already the subject of new and serious debate in corporate boardrooms, in the nation's courtrooms, in physicians' offices and hospital administrators' offices, and, of course, finally in legislatures.

Before turning to the discussion of how each of these participants will face new ethical dilemmas, let me mention that the political process is now beginning to recognize the problems of making the competitive market work, and is beginning to write new "rules of the game" for what different participants can and cannot do in pursuing their economic self-interests.

One statutory change has been new rules by the federal government to define who has to be covered by Medicaid programs. As of 1984 Medicaid has to be extended to children under five in all A.F.D.C. eligible families. That is an expansion that was earlier sought by the Carter administration. Second, also a bipartisan effort, is the recently enacted COBRA legislation, originally sponsored by Senator Edward Kennedy and Representative Pete Stark, which has two major provisions. One provision prevents hospitals from dumping or refusing to treat emergency patients. Unfortunately, a number of hospitals had figured out that the easiest way to protect their bottom line was not to treat emergency patients, particularly if they did not have health insurance. Congress has now said that is not acceptable behavior in a competitive market. The second major provision of COBRA was to extend employment-based health insurance for up to three to four years for individuals who are laid off, for divorced spouses, for dependent children, and for widows. Those people will have to pay the full employer premium to continue coverage, but the legislation guarantees that they will be able to continue employer group insurance and not be dumped into the uninsured.

A third piece of legislation, where the federal government is starting to redefine rules of the market to limit economically self-interested behavior, has been a bill introduced by Mr. Stark to take away the tax-exempt status

of Blue Cross and Blue Shield plans if they do not provide the community service and other benefits which originally earned them their tax exempt status.

Finally, the Kennedy-Durenburger-Stark proposal of last spring is very significant. It is a bipartisan effort by the chairmen of the key health subcommittees in both the Senate and the House. First, it would require all states to establish insurance pools whereby anybody could buy health insurance at 150% or less of the going rate in the state for their age/sex group. That is important legislation. It would assure that people would not be dramatically disadvantaged by being pushed out of employer group coverage. The second requirement to be imposed would be a state system to cover bad debts of hospitals. This would assure that hospitals have payment for the uninsured. And third, there would be some small business subsidies to encourage businesses to expand insurance coverage.

In sum, we are already at the start of a process whereby government is trying to define what is socially acceptable and ethical behavior in a competitive marketplace. And in many instances, where that type of behavior is not being seen in the private marketplace, government is starting to enact regulation that will produce a socially desirable result.

With that as background, let me turn to major ethical and social issues that are going to arise for employers, for insurers, including HMOs and PPOs, and finally for medical professionals. New York has already addressed some of these problems, but many other states are just beginning to face them.

Employers face the most serious set of ethical and social dilemmas and, also, potentially, the expansion of government regulation. There are four major problems. One is the employers' responsibility to pay for the uninsured; second, employment practices; third, health benefits limits and employer intervention in medical decisions; and, fourth, financial solvency of health plans for current workers and retirees.

Employers are beginning to understand that they have increasingly become one of the major financers of health care for the uninsured in this country. This has occurred through hospitals increasing their charges to commercial insurance to cover the costs of the uninsured. In a study done recently by the Urban Institute with the American Hospital Association, we discovered that commercial insurers typically paid hospitals 30% more than the costs of care in 1982. In contrast, Medicare paid 99% of the average cost and Medicaid just 91%. So most of the surplus that hospitals have been able to

generate to take care of the uninsured has come from business payers. Businessmen, as they now go around to hospitals to ask for discounts or to set up preferred provider organization arrangements, are discovering that, as part of their bill, they are asked to pay for the uninsured. And they are being told, "We cannot give you a discount because you have a responsibility, no one else will pick up that bill." So that is the first ethical problem employers face. They can elect to establish their own PPOs and to negotiate lower rates. If they do, and do not assure other ways of serving the uninsured, there will probably be increased dumping of the uninsured. More socially responsible behavior would be to seek all-payer systems, insurance pools and many of the other kinds of measures that expand public and private insurance coverage.

Can we look to the states to pick up more of the costs of the uninsured? Probably not, at least not willingly. One of the interesting trends in the last few years has been the way in which states unbundled their responsibilities for the uninsured and ping-ponged them over to the employers. Medicaid covered about two thirds of the poor in the early 70s, but now less than 50%. State spending for health care is now down to only 10% of national health care spending. It was 12.7% 10 years ago. The 10% state share is now the lowest state share in national health spending in the more than 50 years that we have been keeping national health accounts. So business payers are beginning to discover that, without their knowledge, they have been made the primary financial contributor of health care for the uninsured as government, particularly state government, has slipped out from that responsibility. So I predict that we shall see, and should welcome, some arguments about who is ethically responsible for the uninsured.

Other ethical dilemmas that employers face: number one is employment practices. Employers, as they start to self-insure, are discovering that the easiest way to save money in health care is not to bargain with physicians and hospitals over prices. Frankly, the easiest way for employers to deal with their health costs is simply not to hire people who have high health expenses or a high risk of health expenses, and to lay off or restrict benefits for individuals who have such expenses. AIDS and drug abuse testing have been the most talked about developments recently, but they are just the tip of the iceberg. Employers can now look at their insurance claims, with the help of firms eager to help them, and discover that they have workers who have family members with diabetes, who have alcoholism costs of six to 12 thousand dollars a year, and down the list of all the other high health

expenses. Employers increasingly will have to face up to the decision—with second-guessing by courts and legislatures—as to when and how they use such health data in hiring and in other employment decisions.

Ethical questions and potential regulation also arise in employer policies as to what benefits the employer will provide and interventions when patients are involved in very high expense procedures. Employers can save money if they do not cover procedures such as transplants, or alcoholism, or expensive conditions and types of treatment. These problems have been made much more acute recently because of a mistake in federal regulation. The ERISA legislation that brought federal regulation of pension plans inadvertently exempted self-insuring employers from state health insurance regulation. What that means is that most corporations that are self-insuring are out from under a whole body of state insurance regulation which has been built up over decades. One of the most important areas of exemption has been minimum benefits requirements. Since 1970 virtually every state has enacted minimum benefit laws of some type, e.g., coverage of disabled children. There are now more than 600 statutes on the books. The ERISA legislation has created a vacuum in which no one is regulating or watching self-insured employers. So the potential for abuse in this area is certainly very large.

Ethical issues also arise when employers use case managers to deal with expensive cases. There can be a lot of benefit from good case management of health care. On the other hand, employers are not entering into these medical decisions in the interest of the employees, but to save money for the employers. There are potential conflicts of interest and potential ethical decisions that will have to be looked at in those areas.

Finally, employers face ethical problems in potential governmental regulation of financial solvency of their health benefits plans. As I mentioned, the ERISA legislation exempted self-insuring plans from state regulation. That exemption covers not only minimum benefits, but regulation of financial solvency. We do not know how big a problem there may be among employers who are not putting away enough money to cover health benefits, but it is a potential worry. Even more of a worry than the current problem is making sure that insurance benefits promised to future retirees will actually be there. A forthcoming Department of Labor study will probably estimate that the unfunded liability already incurred by corporations for health benefits of future retirees approaches one hundred billion dollars. Our experience with pension plans is clearly that without government regulation

to assure that those financial obligations are prefunded, they are unlikely to be there. So I would suggest that as a potential agenda item for both state regulation and federal regulation, to insure that corporations meet their ethical responsibilities for prefunding and adequate reserves both for current employees and for the health benefits due to future retirees.

Employers are not alone in facing a great many ethical issues, as they try to make a competitive marketplace work. Two other participants also face difficult ethical judgements and potential government regulation and second-guessing. One is insurers, the other is health care providers. Insurers face many of the same problems as employers who are self-insurers, and I shall not repeat those points. Two specific insurance issues are the skimming of the risk pool and some particular concerns about fiscal solvency.

The problem with skimming the risk pool is that there is a relatively healthy part of the population, perhaps 15 or 20%, that uses almost no health care. And then about 20% or so of the population account for 70 or 80% of total spending. That high expense group is a pretty well-defined part of the population. Many have chronic health problems, and they run up high health bills year after year. So all a new HMO or a new PPO or a new hybrid plan needs to do to make money is to avoid taking the high risk patients. And I submit that skimming the risk pool is in fact how many of the new start-up entrepreneurial operations and HMO and PPOs are making their money. This problem has also been encouraged by inept federal regulation. The federal government has required employers to make the same contribution for an individual joining an HMO as for an individual who stays in the traditional insurance plan. What that means is that if HMOs can attract one of these lower-risk patients, they will be paid the average rate for people who will have health expenses of 20 or 30% below average. That is one reason we are seeing a rapid growth of profitable HMOs. I want to underline, however, that HMOs, PPOs and insurance companies do not need to be unethical to make money this way. People with high health expenses already have established relationships with hospitals and physicians. They do not, by and large, change insurance plans. The people who change to join new plans are, predictably, at much lower risk than average. That is why there is a saying among many insurance executives that in today's market anything new will make money, at least for a couple of years.

That leads to the question: who will take care of high risk patients left behind in this competitive market? It also raises questions about financial solvency. The experience the federal government has had with many of these

HMOs and start-ups is that, while they look promising the first year or two, the long-term prospects are often much more dismal. One reason is that today's new HMO becomes tomorrow's old HMO, its population ages and their health problems start to "regress to the mean," and another HMO can come in and skim their population. The federal HMO development program has seen default rates on federally guaranteed loans of up to 70%. So long-term financial solvency of many of these operations is not assured. And many of us will recall the experience that the MediCal program had in the early 70s when California started contracting with a lot of entrepreneurial HMOs to provide care for their Medicaid populations. It was a public policy disaster and probably set back HMO development in the Medicaid program for 10 years.

Finally, all of these ethical issues faced by employers and insurers ultimately also create serious ethical and professional responsibilities for health care providers. There are lots of ways providers can respond. There are certainly ways to save money in health care. If health care providers are responsible, they will respond to competitive market pressures by producing a more efficient health care system. If they are not, they too can engage in the kinds of behaviors that other participants can engage in to save money in ways that we do not think appropriate. They can dump the uninsured, they can skim paying patients, they can stop treating patients whose costs exceed what will be paid by the Medicare DRG system or by other payers. They can provide second class care for more of our population.

It will be on these health care professionals that much of the bottom line responsibility will fall in the next couple of years. Other participants in our system can evade the responsibility of paying for care, taking care of uninsured and high-risk patients. Ultimately, however, sick patients wind up entering hospital emergency departments or physicians' offices. And it is thus the providers of care who will face the final responsibility for seeing that health care is provided even if the rest of our society does not face up to their obligations and pay their fair share.